

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/26/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBIA HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710			
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F0000	<p>This visit was for the Investigation of Complaint IN00116529.</p> <p>Complaint IN00116529- Substantiated, Federal/State findings related to the allegations are cited at F157, F282, F314, and F329.</p> <p>Survey dates: September 24, 25, and 26, 2012</p> <p>Facility number: 000129 Provider number: 155224 AIM number: 100266780</p> <p>Survey team: Anne Marie Crays, RN</p> <p>Census bed type: SNF/NF: 158 Total: 158</p> <p>Census payor type: Medicare: 26 Medicaid: 113 Other: 19 Total: 158</p> <p>Sample: 24</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>		F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on or after October 8, 2012.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2012

FORM APPROVED

OMB NO. 0938-0391

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	Quality review completed on September 27, 2012 by Bev Faulkner, RN						

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the family and physician were notified of a new pressure area, for 2 of 3 residents</p>			F0157	<p>F157 Notify of Changes (Injury/Decline/Romm,ETC) It is the policy of the facility that the facility will immediately inform the resident;consult with the resident's legal representative or</p>		10/10/2012

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	<p>reviewed for pressure areas, in a sample of 24. Resident B and C</p> <p>Findings include:</p> <p>1. On 9/24/12 at 2:10 P.M., during the initial tour, LPN # 1 indicated Resident B had a pressure area on her right heel. Resident B was observed sitting up in her wheelchair with her feet flat on the floor and wearing slipper socks. LPN # 1 removed the resident's sock, and a dry, brownish, pressure area was observed on the right heel. There was no dressing on the area. LPN # 1 indicated she thought the resident was receiving skin prep to the area.</p> <p>The clinical record of Resident B was reviewed on 9/25/12 at 9:20 A.M.</p> <p>A "Weekly Summary," dated 9/19/12 at 6:37 A.M., indicated, "...Does the resident have any of the following, Open areas - inner left heel/red & open...."</p> <p>Documentation that the physician or family was notified of the new open area was not in the clinical record.</p> <p>Documentation of a new treatment order was not observed in the clinical record.</p> <p>On 9/25/12 at 10:45 A.M., a skin assessment was again requested on</p>		<p>an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident B and C primary physicians have been notified of all skin impairments. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·Residents with a change of condition have the potential to be affected by the alleged deficient practice ·The licensed nurses have been re-educated on residents change of condition, and the skin management program. Timely notification of physician and family of change of condition. Completed by DNS/SDC by October 7, 2012. ·The DNS /designee is responsible to ensure compliance ·Skin sweeps were completed on all residents and any impairment reported to physician <p>What measures will be</p>				

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	<p>Resident B. Resident B was observed lying in bed, with her heels flat on the bed. RN # 2 indicated the resident had pressure areas on both the right and left heel, and was receiving skin prep to both of the areas. The resident's left inner heel had a dry brownish area. RN # 2 indicated the resident should have had her heels floated to relieve pressure on her heels.</p> <p>On 9/26/12 at 10:00 A.M., during interview with the Director of Nursing [DON] and Administrator, the DON indicated she would check with the physician to see if he had documentation of notification of the new area, because she was sure staff had notified him. No further documentation was received by survey exit on 9/26/12 at 3:00 P.M.</p> <p>2. On 9/24/12 at 2:10 P.M., LPN # 1 indicated Resident C had a pressure area on her foot.</p> <p>On 9/25/12 at 8:40 A.M., a wound assessment was requested. PTA # 1 (Physical Therapy Assistant) indicated the resident had a pressure area on her left outer ankle and her left heel. PTA # 1 indicated the resident was receiving electrical stimulation and an allevyn dressing to the areas. The resident had a pressure area on her left heel that was observed to be dry and brown. PTA # 1</p>				<p>put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·The licensed nurses have been re-educated on resident change of condition, and the skin management program. Timely notification of physician and family change of condition. Completed by DNS/SDC by October 7, 2012. ·The facility activity report will be reviewed daily per nurse management to identify and change in condition to ensure physician notification. ·Weekly Summaries/Skin assessment forms will be audited by nurse manager 5x weekly to identify any changes in condition and ensure physician notification. ·Walking rounds will be conducted 5x weekly with members of the IDT to communicate with residents and staff to identify any residents that may be experiencing a change in condition and that physician/family is notified and an appropriate treatment is obtained. ·The DNS/designee is responsible to ensure compliance ·Non-compliance with these procedures and training will result in disciplinary action. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·The change of condition CQI 		

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	<p>indicated the stage was undetermined, "but the area appears to have a small opening in the middle." An additional pressure area was observed on the resident's left outer ankle.</p> <p>The clinical record of Resident C was reviewed on 9/25/12 at 10:00 A.M.</p> <p>A "Therapy Wound Eval [evaluation] and Plan of Care" included: "Observation Date: 9/20/2012- 2:55 P.M....PT [physical therapy] wound re-certification...Reason for referral wounds on left lateral malleolus and left heel...Wound location/number, 1. left lateral malleolus 2. Left heel, Stage of ulcer Other-pressure, Suspected origin, Other-pressure...Wound color 1. black and yellow 2. yellow, Necrotic Slough (%)-80%, Slough (description) - yellow...Current Tx [treatment] order, wound care, debridement and dressing...."</p> <p>A "Pressure Wound Skin Evaluation Report" included: "...Event Date: 9/20/12 9:05 A.M., Completed Date: 9/25/2012- 9:07 A.M...New area, Wound present on admission, No, Date area originally noted 09/20/2012, Stage Unstageable...Necrotic/eschar (Black, brown or tan tissue adheres to wound bed), Site left heel, Describe measurements in cm [centimeters]...4 x</p>				<p>toll will be utilized weekly x4 weeks, monthly x 3 months and quarterly thereafter. For a minimun of 6 months.To be completed by DNS/designee ·All audit tools will be brought before the CQI committee monthly ·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination. Compliance date: October 10, 2012</p>		

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	<p>1.5 x utd [undetermined]...."</p> <p>The most recent wound care order, dated 8/23/12, indicated, "...Clean O/A [open area] to [right] inner ankle [and] [left] outer ankle [with] NS [normal saline] apply Santyl, 2x2 gauze [and] allevyn, [change] daily." The resident's treatment record indicated this treatment was to be completed Monday-Friday by therapy, and Saturday and Sundays by nursing.</p> <p>Documentation that the physician or family was notified of the new pressure area was not observed in the clinical record.</p> <p>On 9/26/12 at 11:30 A.M., during interview with the Director of Therapy, Director of Nursing [DON], Administrator, and PTA #1, the DON indicated therapy was already treating the resident, and notified the physician by sending the physician the therapy plan of care on 9/20/12. The Director of Therapy indicated the plan of care was probably lying on the physician's desk, waiting to be signed.</p> <p>On 9/26/12 at 2:00 P.M., the Director of Therapy provided a copy of the Therapy plan of care, dated 9/26/12, signed by the Nurse Practitioner.</p>						

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	<p>3. On 9/26/12 at 1:30 P.M., the Administrator provided the current facility policy on "Resident Change of Condition," revised 3/10. The policy included: "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs...Routine Medical Change, a. All symptoms and usual signs will be documented in the medical record and communicated to the attending physician promptly...The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift...."</p> <p>This federal tag relates to Complaint IN00116529.</p> <p>3.1-5(a)(1)</p>						

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physician's order was followed for medication administration for 1 of 23 residents sampled related to physician orders and care plans, in a sample of 24. Resident G</p> <p>Findings include:</p> <p>1. On 9/24/12 at 4:45 P.M., RN # 1 was observed to administer to Resident G Comtan 200 mg [a medication used for Parkinson's disease].</p> <p>The clinical record of Resident G was reviewed on 9/24/12 at 6:05 P.M. A physician's order, dated 7/25/11 and on the current September 2012 orders, indicated, "Comtan 200 mg. Take one tablet by mouth 3 times daily 0800 [8:00 A.M.] 1400 [2:00 P.M.] 2000 [8:00 P.M.]." The Medication Administration Record also indicated the medication was to be given at 8:00 A.M., 2:00 P.M., and 8:00 P.M.</p> <p>On 9/24/12 at 6:05 P.M., during interview</p>			F0282	<p>F282 Services by Qualified persons/per care plan It is the policy of the facility that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident G was observed for and sign or symptoms of adverse reaction to alleged drug time/deficient practice and resident is receiving medications per physician order. ·Primary physician of Resident G was notified of alleged deficient practice with no new orders received. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All residents that reside within the facility have the potential to be affected by the alleged deficient practice. ·What measures will be put into place or what systemic changes you will make to 		10/10/2012

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	<p>with RN # 1, she indicated "it was the first time" she was working alone, and she should not have given the Comtan until closer to 8:00 P.M.</p> <p>2. On 9/27/12 at 1:30 P.M., the Administrator provided the current facility policy on "Medication Administration Guidelines," dated 7/2011. The policy included: "...Medications can be administered within a two hour time frame (one hour before to one hour after the time prescribed)...Before giving a medication the nurse must follow the FIVE 'R's'...THE RIGHT TIME...."</p> <p>This federal tag relates to Complaint IN00116529.</p> <p>3.1-35(g)(2)</p>			<p>ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · All nurses/QMAs that pass medications in the facility have received training in regards to the five rights of medication administration. Completed by SDC/DNS/designee by 10/10/2012. · Medication pass validation tool has been implemented by nurse management. · Nurses/QMAs will not be released out of orientation until a member of the nurse management team has completed a medication pass validation tool · All nurses/QMAs that pass medications in the facility have received training in regards to the five rights of medication administration. Completed by SDC/DNS/designee by 10/10/2012. · Nurses/QMAs must pass the medication validation tool error free before passing meds independantly in the facility. · 10% of nurses/QMAs will be observed utilizing the medication pass validation tool monthly by nurse managers to be conducted by all shifts. · Addendum: All physician orders were reviewed and audited by nurse management by September 31 and verified on new MAR for October 1 implementation. An audit of all orders was completed at this time.How the corrective 			

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				<p>action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·All Nurses/QMAs have been educated on the five rights of medication administration. ·10% of nurses/QMAs will be observed utilizing the medication pass validation tool monthly. ·The DNS /designee will complete medication error CQI tool 5X weekly X 4 weeks, weekly X 4, and quarterly thereafter. For a minimum of 6 months ·All audit tools will be brought before the CQI committee monthly ·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination. <p>Compliance date: October 10, 2012</p>			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to notify the physician of a new pressure area and obtain treatment orders or provide pressure relief, to a resident with pressure ulcers, for 1 of 3 residents reviewed with pressure ulcers, in a sample of 24. Resident B</p> <p>Findings include:</p> <p>1. On 9/24/12 at 2:10 P.M., during the initial tour, LPN # 1 indicated Resident B had a pressure area on her right heel. Resident B was observed sitting up in her wheelchair, with her feet flat on the floor, wearing slipper socks. LPN # 1 removed the resident's sock, and a dry, brownish, pressure area was observed on the right heel. There was no dressing on the area. LPN # 1 indicated she thought the resident was receiving skin prep to the</p>		F0314	<p>F314 Treatment/svcs to prevent/heal pressure sores It is the policy of the facility that the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident B has been evaluated by therapy for proper wheelchair positioning. · Resident B has appropriate treatment order in place. ·Resident B has appropriate pressure relieving devices ordered and care planned. <p>How will you identify other</p>		10/10/2012	

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	<p>area.</p> <p>On 9/24/12 at 3:55 P.M., Resident B was observed sitting in a wheelchair with her feet flat on the floor.</p> <p>The clinical record of Resident B was reviewed on 9/25/12 at 9:20 A.M.</p> <p>Physician orders, initially dated 4/19/12 and continued on the September 2012 orders, indicated, "Skin prep...Apply to left heel every shift Leave open to air."</p> <p>A care plan, dated 5/2/12, indicated, "Problem, Resident has impaired skin integrity: pressure area to right heel." The Approaches included: "Pressure reducing/redistribution cushion in chair, Pressure reducing/redistribution mattress on bed, Treatment as ordered, Turn and reposition every 2 hours...."</p> <p>A Minimum Data Set [MDS] assessment, dated 7/30/12, indicated the resident scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assistance of two+ staff for bed mobility and transfer, and did not ambulate. The MDS assessment indicated the resident had 1 unhealed pressures ulcer, which was a Stage 2.</p>				<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents that have pressure wounds have the potential to be affected by the alleged deficient practice. · Care plans of any resident with pressure wounds have been reviewed and updated if indicated. ·Nurse managers will round daily to ensure proper pressure relieving/reducing devices are in place for any resident that has pressure related wounds and C.N.A. assignment sheets have been updated according to care plan. ·Audit has been completed by DNS to ensure any resident with pressure wounds has the appropriate treatment in place and physician has been updated with current measurements and assessment of pressure wounds. ·Addendum: Skin sweep was completed on 10/4/2012 by nurse management <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Licensed nursing staff has been educated on wound prevention policy by DNS/SDC by 10/10/2012. ·DNS/Designee/UM will conduct rounds daily on all shifts to validate that all pressure 		

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	<p>A "Weekly Summary," dated 9/19/12 at 6:37 A.M., indicated, "...Does the resident have any of the following, Open areas - inner left heel/red & open...."</p> <p>Documentation that the physician or family was notified of the new open area was not in the clinical record.</p> <p>Documentation of a new treatment order was not observed in the clinical record.</p> <p>A "Pressure Wound Skin Evaluation Report," completed 9/25/12 at 8:48 A.M., indicated: "...Right heel, existing area, Wound present on admission, Yes...Stage II...1.6 x 1.4 x S...Describe wound drainage, scant serous...."</p> <p>On 9/25/12 at 10:45 A.M., a skin assessment was again requested on Resident B. Resident B was observed lying in bed, with her heels flat on the bed. RN # 2 indicated the resident had pressure areas on both the right and left heels, and was receiving skin prep to both of the areas. The resident's left inner heel had a dry brownish pressure area. The resident's right outer heel had a pressure area which appeared dry and brown. RN # 2 indicated the resident should have had her heels floated to relieve pressure on her heels. RN # 2 indicated the resident had previous pressure ulcers on her heels, which had not responded well to</p>		<p>reducing/relieving interventions are in place and functioning properly.</p> <p>·C.N.A. assignment sheets have been updated to reflect current measures according to plan of care.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Staff has been educated on wound prevention policy.</p> <p>·The DNS/designee will complete wound CQI tool 5X weekly X 4 weeks, weekly X 4, and quarterly thereafter. For a minimum of 6 months</p> <p>·All audit tools will be brought before the CQI committee monthly</p> <p>·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination.</p> <p>Compliance date: October 10, 2012</p>				

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	<p>dressings and ointments, and that is why the areas were left open to air.</p> <p>On 9/26/12 at 10:00 A.M., during interview with the Director of Nursing [DON] and Administrator, the DON indicated Resident B had a previous pressure ulcer on the left heel which had been treated with skin prep, and she thought the physician had been notified to continue the skin prep. The DON indicated she was not treating the area as a pressure area, because although it had been a previous pressure area, she thought it had occurred due to a previous fall.</p> <p>2. Stages of Pressure Ulcers, AMDA (American Medical Director's Association) - 2008, included: <u>Stage II</u>: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister. Note: This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. <u>Stage III</u>: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p>						

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	<p>3. On 9/26/12 at 1:30 P.M., the Administrator provided the current facility policy on "Skin Management Program," revised 6/12. The policy included: "...Alterations in skin integrity will be reported to the physician and family member(s). Physician orders will be obtained for all alterations in skin integrity identified...Pressure reduction devices are to be put in place immediately...The care plan will be initiated/revised addressing any new areas...."</p> <p>This federal tag relates to Complaint IN00116529.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>						

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure adequate indications for the use of an anti-anxiety medication, Lorazepam, for 1 of 3 residents reviewed receiving psychotropic medications, in a sample of 24. Resident A</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident A was reviewed on 9/25/12 at 1:15 P.M. Diagnoses included, but were not limited</p>		F0329	<p>F329 Drug regimen is free from unnecessary drugs It is the policy of the facility that each resident's drug regimen is free from unnecessary drugs . What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident A no longer resides in the facility.How will you identify other residents having the potential to be affected by the same deficient practice and</p>		10/10/2012	

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	<p>to, dementia.</p> <p>The resident was admitted to the facility on 4/25/12. A Physician's order, dated 4/25/12, indicated, "Lorazepam 0.5 mg, Take 1 tablet by mouth 3 times daily as needed for anxiety/agitation (For Ativan 0.5 mg)."</p> <p>The resident's Medication Administration Record [MAR], dated June 2012, indicated the resident received Lorazepam on June 5, 7 and June 18. The reverse page of the MAR indicated:</p> <p>"6-7-12, Ativan 0.5 mg 1600 [4:00 P.M.] for [increased] agitation, anxiety." The "Results/Response" section was left blank.</p> <p>"6-7-12- 2315 [11:15 P.M.] Ativan 0.5 mg [one] po [by mouth] [increased] agitation, anxiety. Results/Response effective 0015 [12:15 A.M.]."</p> <p>6-18-12, time illegible, Ativan 0.5 mg [one] po agitation. Results/Response slightly effective [time illegible]."</p> <p>Nursing progress notes did not address the resident's agitation on 6/7/12. A progress note, dated 6/8/12 at 2:00 A.M., indicated, "Sleeping quietly @ this time, was given Ativan earlier d/t [due to]</p>		<p>what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents that have an order for PRN antianxiety medication have the potential to be affected by the alleged deficient practice. ·Every resident's medication regimen has been reviewed by SS and Nurse management. ·Medication changes have been made according to the residents needs. ·Any new admission that admits to the facility with a PRN antianxiety order will be placed on a clinical monitoring tool to be reviewed by IDT within 7 days to determine if med is appropriate. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Licensed nursing staff have been educated on proper procedure to document and administer PRN antianxiety medication and taught appropriate interventions to attempt prior to medication administration. Completed by SDC/DNS by 10/10/2012 ·SSD/DNS must be notified prior to administration of any PRN Antianxiety ·DNS/designee will review narcotic count sheet and MAR of any resident with a PRN order for Antianxiety daily to ensure that nonpharmacological interventions 				

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	<p>increased agitation and anxiety. Medication was effective. Safety measures are in place and functioning. Prior to giving the Ativan, po fluids, food, going to BR [bathroom], and 1:1 was done."</p> <p>Nursing progress notes did not address the resident's agitation on 6/18/12.</p> <p>The MAR, dated July 2012, indicated the resident received Lorazepam on 7/10, 7/19, 7/25, and 7/27. The reverse of the MAR documented one entry that the resident received the Lorazepam, on 7/10/12. This entry indicated, "[Time illegible] Lorazepam 0.5 [one] po, Reason anxiety, Results/Response effective 2100 [9:00 P.M.]."</p> <p>Progress notes did not address the resident's anxiety on 7/10/12.</p> <p>Progress notes, dated 7/19/12 at 1:45 P.M., indicated, "...Remains confused...Non-compliant with waiting for assistance in getting up. Attempts to get out of bed and w/c [wheelchair] by herself...."</p> <p>There was no documentation on 7/19/12, 7/25/12 or 7/27/12 regarding increased agitation or anxiety.</p>		<p>were attempted prior to administration. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Staff have been educated on proper procedure to document and administer PRN antianxiety medication and interventions to attempt prior to medication administration. Completed by SDC/DNS by October 12, 2012. ·The Social Services Director /designee will complete CQI tool 5X weekly X 4 weeks, weekly X 4, and quarterly thereafter. For a minimum of 6 months ·All audit tools will be brought before the CQI committee monthly ·Any non-compliant issues may be addressed with re-education and/or disciplinary action up to and including termination. <p>Compliance date: October 10, 2012.</p>				

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	<p>The MAR, dated 8/12, indicated the resident received Lorazepam on 8/21 and 8/26. The reverse of the MAR did not include documentation for the reason of the medication.</p> <p>A Progress note, dated 8/22/12 at 10:49 P.M., indicated, "Very agitated earlier. Refused all meds and was yelling out. Even removed her colostomy bag, which was replaced. Finally able to get resident to take a dose of prn [as needed] Ativan, crushed in yogurt."</p> <p>The next entry, dated 8/26/12 at 5:19 P.M., indicated, "Agitated and yelling out...Given prn dose of Ativan and given pudding. Taken to room per Dtr [daughter]."</p> <p>A care plan, dated 7/23/12, indicated: "Problem, Behavior: [Resident A] has episodes of being very restless, yells out, demands snuf [sic]...Approaches...Give snuf routinely to prevent behaviors from occurring...Use loud tone when communicating as [Resident A] is very hard of hearing...Provide reassurance that she is safe...Encourage family to visit and be supportive as needed...."</p> <p>On 9/26/12 at 10:00 A.M., during interview with the Administrator and Director of Nursing [DON], the DON</p>						

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	<p>indicated the facility began a new behavior program on 8/1/12, to try and obtain better documentation for when the use of prn medications are used. The Administrator indicated the family of Resident A "wanted her to have the Ativan."</p> <p>2. On 9/26/12 at 1:30 P.M., the Administrator provided the current facility policy on "Psychotropic Medication Management Program," undated. The policy included: "It is the policy of [facility corporation] to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being. These medications are managed in collaboration with the attending physician, pharmacist and facility staff to include behavioral interventions, assessment and reduction as applicable...."</p> <p>On 9/26/12 at 1:30 P.M., the Administrator provided the current facility policy on "Medication Administration Guidelines," dated 7/2011. The policy included: "...A nursing assessment of the resident and symptoms prior to administration and results are to be documented. Complete documentation of PRN medication must be documented in the nurses notes, or in the area provided</p>						

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	<p>for PRN documentation on the medication administration record...."</p> <p>This federal tag relates to Complaint IN00116529.</p> <p>3.1-48(a)(4)</p>						